TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR SURGICARE AT NORTH DALLAS

Respondent Name
DALLAS ISD

MFDR Tracking Number
M4-17-0292-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
OCOTBER 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility name changed during the DOS 4/8/16 which I'm assuming could have caused the claim to not be paid. Argus reached out to me for a W-9 which was sent, and then one claim was paid but not the other."

Amount in Dispute: $2,846.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The DWC 60 indicates the issue is in regards to the ambulatory surgical center reimbursement for date of service 04/28/2016. However, the CMS 1500 indicates a date of service 04/08/2016. The enclosed CMS 1500 for date of service 04/08/2016 indicates Dallas ISD received the bill on August 16, 2016."

Response Submitted By: Argus

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 2016	Ambulatory Surgical Care Services CPT Code 26952-F2	$1,897.70	$0.00
	Ambulatory Surgical Care Services CPT Code 26055-F2	$948.86	$0.00
TOTAL		$2,846.56	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.

2. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
3. The services in dispute were reduced / denied by the respondent with the following reason code:
   - 29-E-The time limit for filing has expired. Claim is to be submitted no later than the 95th day after the date on which the health care services are provided.

Issues

Did the requestor support position that the disputed bills were submitted timely?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "29-E-The time limit for filing has expired. Claim is to be submitted no later than the 95th day after the date on which the health care services are provided."

Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

In support of the position, the requestor submitted the *Insurance Billing History* report that indicates DISD was billed on April 18, August 10 and September 27, 2016 via Paper. This report does not indicate a date of personal delivery or a postmark letter to support that the disputed bills were submitted timely in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/3/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.